APPENDIX K

Task Force on Minority Health Report,
Executive Summary

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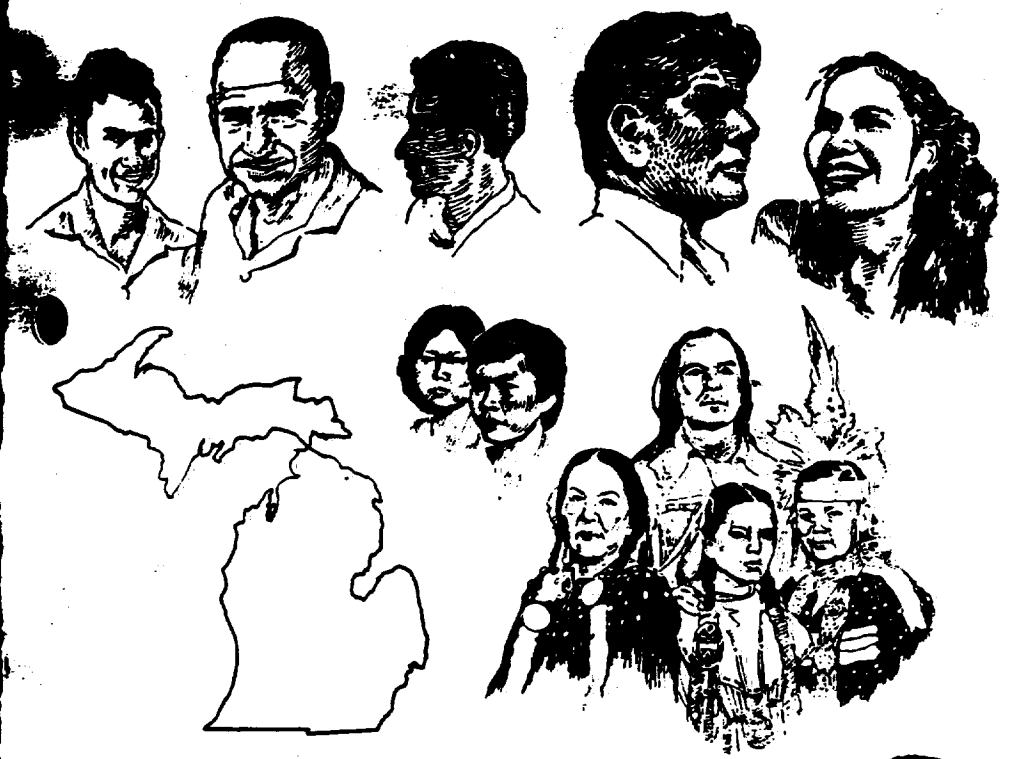
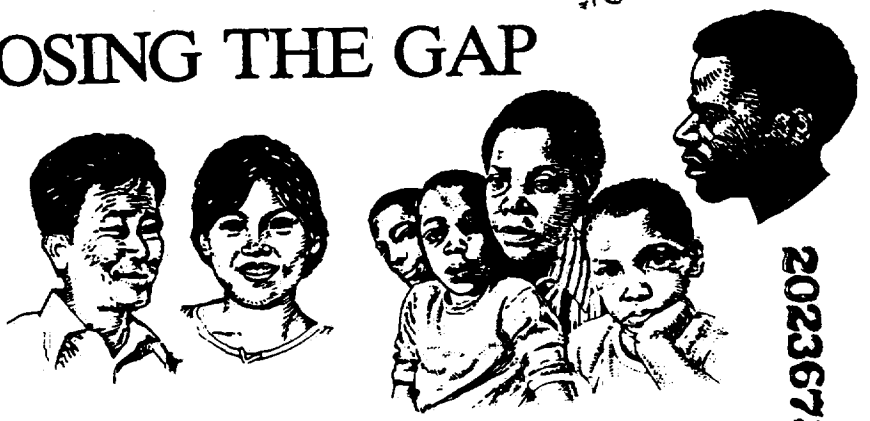
Minority Health in Michigan



CLOSING THE GAP



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Michigan Department of Public Health 1988

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FOREWORD

There is a distressingly wide, and in some cases, growing gap in health status between the minority Black, Hispanic, Arab American, Asian/Pacific Islander, and Native American population and the majority population in Michigan. Heart disease, cancer and homicide death rates are all rising for minorities. The minority infant mortality rate as well as the mortality rates for diabetes, accidents, and cirrhosis are, at best, stagnating.

In 1985, Michigan's minority death rate exceeded the national level by 18 percent.

The pervasiveness and severity of health problems experienced by Michigan minorities led former state health director Dr. Gloria Smith to convene a group of scientists, health professionals and public policy leaders to examine the nature and causes of the discrepancy in health status between minorities and Whites and to recommend potential remedies to close this gap. I strongly endorsed this initiative and now believe that closing the minority health gap should be the number one priority for the public health community.

All of Michigan has a major stake in improving the health of the minority population. With nearly one in five residents now belonging to a minority group, our ability to be economically competitive in a highly technological society depends on good health and high educational levels in both the White and minority communities. Additionally, our efforts to reduce health care costs and improve the overall quality of life in our state will depend on progress being made by all groups in reducing rates of illness and injury.

We now have sufficient data to both awaken our sensitivity and guide policy initiatives.

As the task force report unfolds, it will be apparent that positive results will not be easily attained, but will require persistent and continuing attention now and in the years ahead. Decisive and coordinated action on the part of business, labor, government, voluntary agencies and individuals to faithfully implement the six major recommendations will bring us closer together and benefit the entire state.

Accordingly, I wish to thank the leadership and members of the Task Force on Minority Health Affairs, not only for a job well done, but for a job well begun.

Raj M Wiener

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The Honorable Tony Benavides

Vice-Chair
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Charles Waugh, JD
Claud Young, DO

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Ad Hoc Members

Annette Abrams
Jon Beasley
Jan Chabut
Lawrence Chadzynski
Edie Clark
Chester Eagleman
Pam Paul-Shaheen
Karen Schrock
Jeffrey R. Taylor, PhD
John Trotter
Wayne Verspoor

Project Staff

Research Dir, Martin Halpern, PhD
Kathleen M. Beisel, PhD
Keith Bletzer
Sharon Hobbs, PhD
Jacqueline Flowers Lee
Dianne Kalnins
Dean Sienko, MD
Jacquelynn K. Gilbert
Diane Knott

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EXECUTIVE SUMMARY

INTRODUCTION

The wide discrepancy in mortality rates between the minority population of Blacks, [illegible]ics, Arab Americans, Asian/Pacific Islanders, and Native Americans and the White [illegible]tion appears to be growing. For a number of causes of death, minorities have [illegible]ced increases in mortality rates in recent years.

The extent of the health problems affecting minorities was first documented in a [illegible]deral report by the Secretary of Health and Human Services. It was determined [illegible] of minority excess deaths (when compared to white death rates) fell into six [illegible] areas: heart disease and stroke; cancer; homicide and accidents, infant [illegible]y, cirrhosis and diabetes.

The minority population in Michigan has increased rapidly in recent years. The [illegible]t 1985 minority population estimate, which adjusts for past under-counting, is [illegible]t 1.8 million. This is about 19.4 percent of all Michiganians.

Minority Population in Michigan, 1985

Minority Group	Number	Percent
Black	1,344,477	14.79%
Hispanic	184,592	2.03%
Arab American	100,182	1.10%
Asian/Pacific Islander	76,141	0.84%
Native American	62,927	0.69%
Total Minority Population	**1,758,220***	**19.35%**

*Note. Total is reduced by 10,099 to avoid double counting the Black Hispanic population.

Minorities now constitute nearly one in five of all Michigan residents. Realizing the potentially severe impact of health problems on this population, the Department of Public Health convened a task force of distinguished scientists and public health leaders to examine the broad array of minority health issues and formulate an action plan. The task force was supported by staff drawn from all parts of the State Health Department and coordinated by the Division of Research and Development in the Center for Health Promotion. Acting State Health Director, Raj M. Wiener, personally directed the meetings and activities of the task force, and made "Closing the Minority Health Gap" a major focus of the administration.

Improving minority health status is a matter of simple justice. Also, a concentrated effort designed to reduce health risk factors and improve access to care for minorities will bring immediate and beneficial economic and social benefits for the state as a whole. For what state, or what nation, can long survive if one-fifth of its population fails to reach its full potential and make its unique gifts available to society?

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Blacks

Blacks are the largest minority group in Michigan. They are an almost entirely urban population. Since Blacks represent 75% of all minorities, the overall health status of minorities tends to reflect the Black experience.

Michigan death rates for Blacks are substantially higher than White rates for heart disease, cancer, stroke, pneumonia and influenza, diabetes, and for chronic liver disease and cirrhosis. The infant mortality rate for Blacks is two and one-half times the White rate and the homicide rate for Blacks is over twelve times higher than that for Whites.

Blacks also have higher prevalence rates of a number of key risk factors. Hypertension, a risk factor for cardiovascular and cerebrovascular disease, is one and one-half times as common in the Black population in Michigan as it is in the White population. The prevalence of cigarette smoking is substantially higher in the Black community than in the White community. Obesity is much more common among Black women than among White women. Poor access to early detection and treatment services for diseases such as cancer appears to be a significant factor in the elevation of mortality rates for Blacks. Inadequate access to prenatal and postnatal care services contributes to the very high rates of infant mortality in the Black community.

Hispanics

Hispanics are the second largest minority group in Michigan. Hispanics of Mexican origin are the largest subgroup with others coming from more than a dozen Spanish speaking countries.

As is the case for other population groups, diseases of the heart and cancer are the leading causes of death. Although the Hispanic overall cancer prevalence rate appears to be lower than the non-Hispanic White rate, rates for gallbladder, stomach, cervical, and renal malignancies are elevated for Hispanics. Hispanics appear to have a greater prevalence of such risk factors as hypertension and obesity than is the case for the non-Hispanic White population. Diabetes prevalence also appears to be elevated. Hispanic males are more likely than non-Hispanic White males to be victims of violence.

Hispanics are twice as likely as Whites to be uninsured. Access to care may thus be financially difficult or impossible, a problem compounded by linguistic and cultural barriers.

A Department of Mental Health needs assessment found, "the most serious problems overall (among Hispanics) are unemployment and substance abuse. The problems most commonly identified as emotional or mental were depression and alcoholism."

Arab Americans

Arab Americans trace their origins to many different Middle-Eastern countries. The largest subgroup is Lebanese with Arabians, Assyrian, Syrians and Iraqis among the other major ethnic groups. Three-quarters of Michigan Arab Americans live in the metropolitan Detroit area. The rapid growth of the Arab population is directly attributable to immigration from the war-torn Middle East. The south end of Dearbo serves as an immigrant reception area.

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Although data is scarce on several of the minority groups within Michigan, it haps is more sparse for Arab Americans than for any other minority group. Several ent studies have focused on prenatal and postnatal health care needs of Arab erican women in the greater Detroit metropolitan area. A recent parenting survey nd that Arab American women marry at a young age and begin child-bearing early. quent pregnancies lead to complications and often result in high infant death rates. ditionally, language and culture differences are major barriers to obtaining health

n and Pacific Islanders

This population also comes from many countries around the world. The largest bgroup is Asian Indians, followed by Filipinos, Chinese, Koreans, Japanese and ietnamese.

Heart disease and cancer have consistently been the two leading causes of death in e Asian and Pacific Islander population in Michigan, as in the non-minority opulation. Asian and Pacific Islanders, however, have lower heart disease and cancer ortality rates than do Whites. These differences may be due to culturally influenced ehaviors involving diet, smoking, and alcohol consumption. There is evidence, however, these behavioral and disease patterns change as immigrants adopt United States ral patterns over time.

Accidents were responsible for approximately 12 percent of the Asian and Pacific Islander deaths in Michigan in the past three years, about three times the frequency of his cause among Whites.

Tuberculosis, although not a major cause of death, is a serious health problem among Asian and Pacific immigrants. The rate for Asian and Pacific Islanders is more than twenty times the White rate. The federal Centers for Disease Control in Atlanta estimates that half of these cases are preventable with appropriate screening and treatment.

Native Americans

American Indians from three major tribal groups - Ojibwa (Chippewa), Odawa (Ottawa) and Potawatomi - form the bulk of the Michigan Native American population. There are six federally funded recognized reservations in Michigan serving about 10,000 people. The majority of Michigan Indians, however, live in urban areas, with one-third of the total in the Detroit metropolitan area.

The percentage of total deaths from accidents, chronic liver disease, suicide and diabetes was higher among Native Americans in Michigan (1984-1986) than for all Michiganians in 1985. The first three causes of death may be directly or indirectly related to alcohol abuse, which is one of the most critical health problems among American Indians.

Access to care is problematic. Whites often assume that Native Americans get all necessary health care from the Indian Health Service. This is not true.

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EXCESS MINORITY DEATHS

Minority excess deaths are those which would not have occurred if the mortality rates for minorities had been the same as the rates for the White majority.

Michigan age-adjusted death rates in 1985 were higher for minorities than for Whites for the four leading causes of death and for seven of the ten leading causes. Rates for minorities were 27 percent higher for both diseases of the heart and for cancer, the two leading causes of death. Overall, the age-adjusted death rate was 48 percent higher for minorities than for Whites.

If there were no disparity in death rates, there would have been 3,241 fewer minority deaths in 1985 (a total of 7908 deaths instead of the actual total of 11,149). The major causes of excess deaths to minorities in 1985 were:

Condition	1985 Excess Minority Deaths
Heart Disease	658
Homicide	653
Cancer	473
Infant Mortality	289
Liver Disease	209
Stroke	206
Diabetes	91
Accidents	32

Heart Disease and Stroke

In this country, cardiovascular and cerebrovascular diseases lead to more deaths, disability and economic loss than do any other group of illnesses. Diseases of the heart were the leading cause of death in 1985, both nationally and in Michigan. Heart disease death rates are substantially higher for minorities in Michigan than for minorities nationally. In 1985, the Michigan heart disease mortality rate for "other than Whites" was 27 percent higher than that for Whites. Nationwide, the 1984 heart disease death rate for "other than Whites" was 18 percent higher than that for Whites.

Hypertension, or elevated blood pressure is an important risk factor leading to cardiovascular and cerebrovascular diseases. Blacks have a much greater prevalence of hypertension than do Whites. Black women are at higher risk than Black men. Among the factors suggested as contributing to the higher prevalence of hypertension among Blacks are low income, low levels of social support, a lower ratio of potassium to sodium in the blood, and a greater prevalence of obesity.

Other important risk factors for heart disease are high cholesterol, cigarette smoking and lack of regular aerobic exercise.

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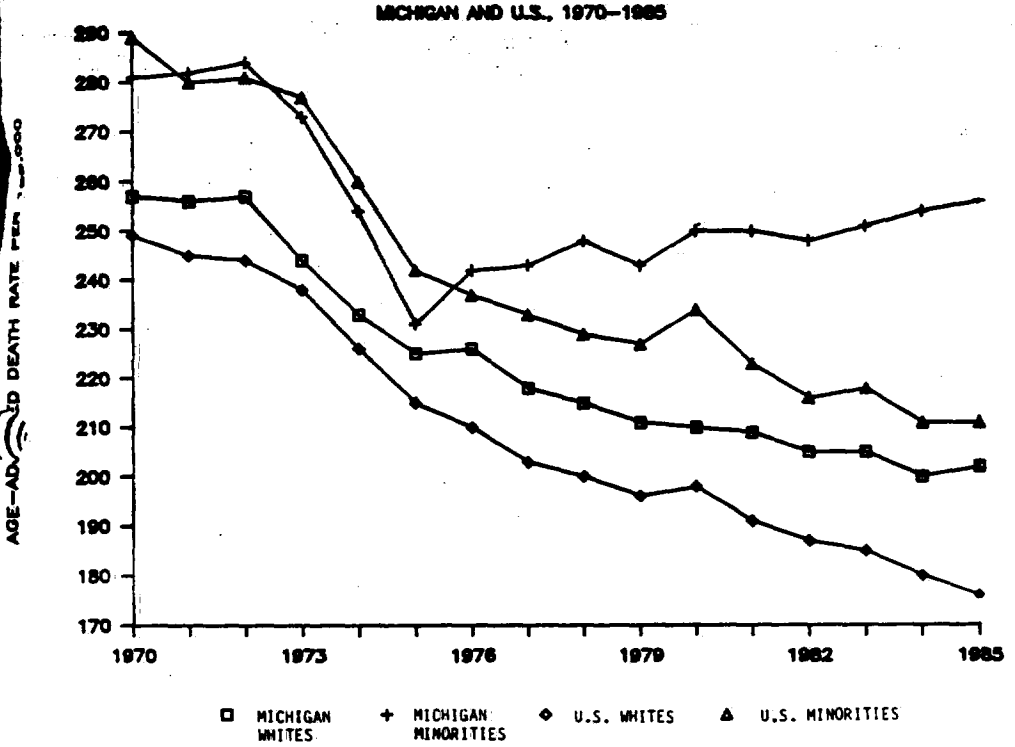
Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

AGE–ADJUSTED HEART DISEASE DEATH RATES

MICHIGAN AND U.S., 1970–1985



Homicide

The homicide death rate for Blacks is about a dozen times higher than that for Whites. The vast majority of the 709 Black homicide deaths in 1985 were excess deaths, deaths that would not have occurred if the rate for the Black population was the same as that for the White population. Nearly 500 of the Blacks who died by homicide were individuals under the age of 35 years.

A new public health statistic, "Years of Potential Life Lost (YPLL)", dramatizes the impact of violence. In 1985, there were 19,041 years of life lost prior to age 65 by Michigan Black males because of homicide. This represents 22 percent of the total years of life lost before age 65 by Black males as a result of all causes of death.

Sixty percent of Michigan homicide deaths occurred in the City of Detroit as did 76 percent of Black homicide deaths. Other counties in addition to Wayne (34.6 deaths per 100,000 population) with double digit homicide rates in 1986 were Genesee (17.1) and Saginaw (15.7).

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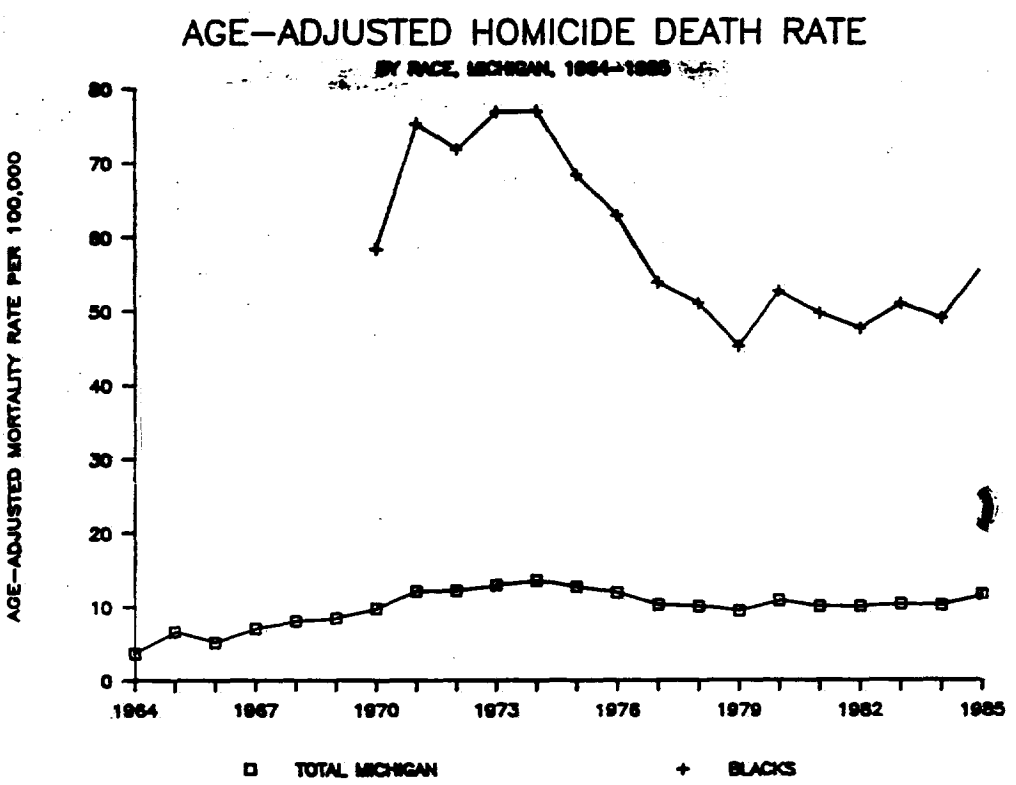

Gun-related killings accounted for 73 percent of all Black homicides in 1986. Also, about half of the 10,000 1985 hospital discharges involving homicides and injuries purposely inflicted on another person involved minority victims. As many as half of all homicides are alcohol-related. Homicides are also often preceded by patterns of non-fatal violence such as assaults, spouse abuse, child abuse and self-inflicted injury.

A whole generation of minority youth is in danger. The symptoms of the problem are violence, drug and alcohol abuse, teenage pregnancy and dropping out of school. The reality of unemployment combined with the accelerating decay of city neighborhoods and the easy availability of drugs present huge obstacles to child rearing in minority communities.

Cancer

Cancer is a leading cause of death, second only to heart disease. Ten years ago in Michigan, the cancer mortality rate for "Other than Whites" was 26 percent higher than for Whites. In 1984, the gap in Michigan was 28 percent, higher than the nationwide difference of 21 percent.

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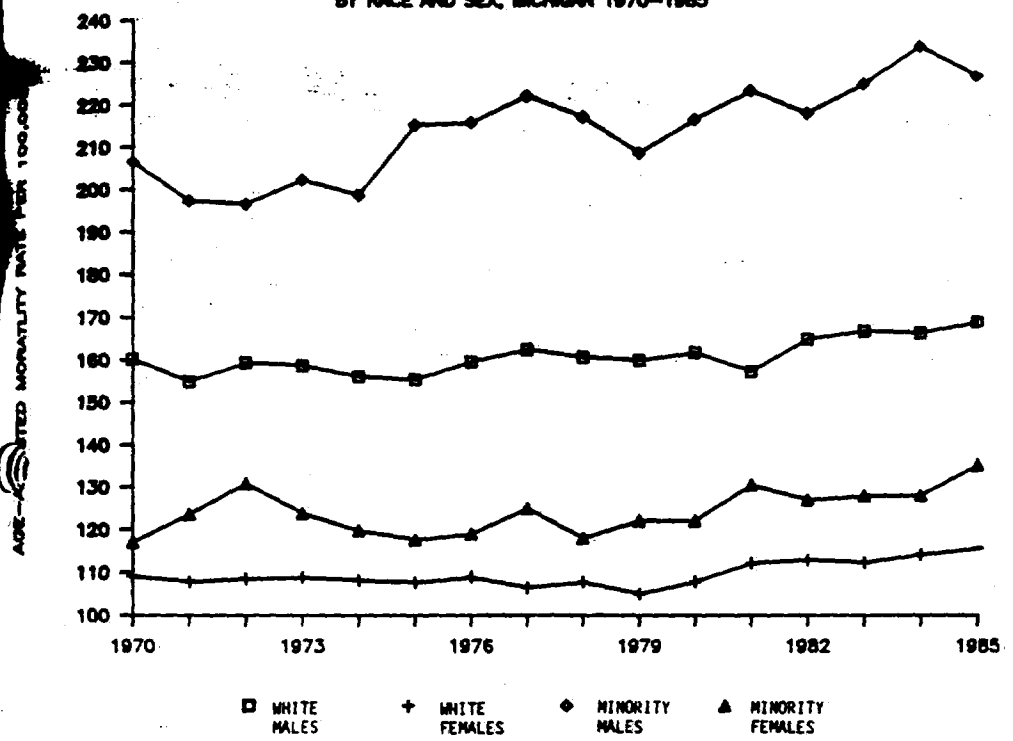
AGE–ADJUSTED CANCER DEATH RATES

BY RACE AND SEX, MICHIGAN 1970–1985



In 1985, new cancer cases were found 20 percent more frequently among Blacks than Whites. Elevated cancer rates among Blacks include lung, cervical, stomach and prostate.

Several behavioral risk factors such as tobacco use, poor nutrition, and high alcohol consumption are related to the increased occurrence of cancer. The primary factor in elevated cervical cancer deaths are lack of access to preventive medical care (PAP tests), particularly among post-menopausal women.

Occupational exposures to asbestos, benzene, chromium, agricultural chemicals and air-borne dust are often even more lethal when combined with behavioral risks such as smoking and alcohol consumption. Minorities in manufacturing, service and agricultural jobs need to know about occupational exposures they may be facing and of ways to protect themselves through safer work environments and reduction of behavioral risks which aggravate the dangers.

Hispanics, Asian/Pacific Islanders and Native Americans have lower overall cancer rates than Whites. This may be a result of lower behavioral risks in the case of

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Hispanics and Asian/Pacific Islanders. There are, however, particular types of cancer such as stomach cancer, which in the Hispanic and Japanese-American population have incidence rates double that of Whites. This may be due in part to the consumption of heavily spiced, pickled and smoked food. Chinese-Americans and Hispanics have an excess incidence of cervical cancer. This is particularly distressing since every death to invasive cervical cancer is totally preventable with today's health care technology.

Infant Mortality

The death of a baby before the child reaches his/her first birthday is a tragic personal loss for the family and a social loss for the community as a whole. The infant death rate is more than a health indicator; it is a measure of the quality of life for the entire population.

Declines in infant death rates were observed during the 1970's, but the rate of decline has been smaller for minorities than for Whites. As a result, the racial gap in infant mortality has been growing in Michigan. In 1970, the Black rate was 63 percent higher than the White rate, but by 1986, the Black rate was 156 percent higher.

Native American infant death rates in 1984 were 26 percent above the White rate. The rate for other races, mostly Asian and Pacific Islanders is close to that of White. Accurate data on Hispanic infant deaths will not be available until the new birth certificate becomes available in 1989. A study by the Wayne County Health Department indicates that the infant mortality rate among the Dearborn Arab community is quite high.

Many factors are involved in high minority infant death rates including, poverty, lack of prenatal care, teenage pregnancy, substance abuse and inadequate diet. The economic circumstances faced by minorities combined with poor access to preventive health care are conditions which increase the number of babies born too small, too soon. In turn, this has increased the health costs for hospital-based intensive care for both high-risk mothers and infants.

Alcohol and Drug Abuse

Excessive drinking can lead to many adverse health outcomes including cirrhosis of the liver. Minority groups experience higher rates of alcohol-related illness and death than do Whites. Among women, abusive drinking is more likely to occur among Blacks than Whites. Also, Native Americans are significantly more likely to be alcoholic than are Whites.

The racial discrepancy in cirrhosis mortality rates was especially large for Michigan in 1984. For the U.S. as a whole in 1984, the other-than-White rate was 1.5 times higher than the White rate (14.3 vs. 9.3) while in Michigan the other than White rate was more than twice as great as the White rate (25.4 vs. 10.0).

Michigan hospital discharge data for 1985 reveal that Black and other minority males were roughly twice as likely to have been hospitalized with a primary diagnosis relating to alcohol abuse as White males (White: 351.0; Black: 753.0; other minority: 619.0). Minority women were more likely to be hospitalized for alcohol-related illnesses than were their White counterparts (White: 96.2; Black: 162.0; other minority: 242.0) [Note: all rates are per 100,000 population.]

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Source: https://www.industrydocuments.ucsf.edu/docs/mjl0000

Notwithstanding their increased death and illness risk from alcohol related disease, Blacks do not appear to be heavier drinkers than Whites. For example, a 1987 Michigan survey reveals that Blacks and Whites have similar percentages of heavy drinkers (Whites 9.2% and Blacks 7.3%). The fact that Blacks do not appear to be more likely to drink excessively than Whites, in spite of a greater likelihood of suffering from the ill effects of alcohol, may indicate that other environmental factors such as poverty, poor education, and poor nutrition have exacerbated the negative consequences of alcohol abuse.

Native Americans are particularly hard-hit by cirrhosis deaths, especially in the younger age groups. In fact, alcohol is viewed as "the most critical health problem among Michigan Indians".

Mind-altering substances, like alcohol, while holding out hope of escape from unpleasant living conditions, destroy physical and mental health. The addicted individual is often unable to learn and work, thereby further decreasing life opportunities.

Diabetes

Diabetes is a disease characterized by abnormally high levels of glucose in the blood resulting from the body's failure to properly metabolize carbohydrates, fats and proteins. About 5-10 percent of diabetics are dependent on daily injections of insulin. Most persons with diabetes develop their symptoms after age 40 and are managed through diet, weight control, exercise, and insulin or oral medicine. Common complications of diabetes include blindness, limb amputation, kidney failure, and birth defects in children born to diabetic mothers.

Diabetes is more prevalent in minority populations than in the White population. Blacks, Hispanics, Native Americans and Japanese Americans all have elevated diabetes prevalence rates. In a 1983 random sample of Michigan's population, the diabetes prevalence rate was 5.5 percent among Black adults, which was 1.53 times the White rate of 3.6 percent. This discrepancy is especially great among women, with Black women having a prevalence rate 80 percent greater than the White rate.

Appropriate medical care for diabetes includes prescribing the right medication, diet and exercise and also providing comprehensive instruction about the therapies and self-care activities which actively support patient self-reliance and responsibility. The prescribed diet must be tailored to the patients' social and ethnic background and lifestyle to ensure compliance.

AIDS

AIDS is a particularly deadly disease. About 50 percent of persons diagnosed as having AIDS die within a year of diagnosis. About ninety percent die within five years.

The bulk of AIDS cases have occurred among certain sub-groups of the population. Sixty-one percent of cases were males with a history of homosexual/bisexual contact, 17 percent of cases reported intravenous drug use, and 7 percent reported both homosexual/bisexual contact and intravenous drug use.

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The racial breakdown of these cases showed that 55 percent were White, 44 percent were Black, and the remaining one percent consisted primarily of Hispanics. Race-specific AIDS case rates were 3.7 per 100,000 for Whites and 17.9 per 100,000 for Blacks. The Black rate was 4.8 times higher than the White rate. National data also show higher rates for minorities than for Whites.

Michigan AIDS Cases by Race

January 1, 1988

Race/Population	No. of Cases	Rate per Population
White	283	3.70
Black	227	17.94
Hispanic	6	3.70
Other	2	***
TOTAL	518	5.70

Approximately 40 percent of Michigan Blacks with AIDS are believed to have contracted the disease through male homosexual/bisexual contact. The remainder of Michigan Blacks with AIDS contracted the disease by intravenous drug use, heterosexual contact and blood product transfusion. Eight Black children in Michigan contracted AIDS through prenatal transmission from AIDS infected mothers.

The potential for heterosexual spread of AIDS in the minority populations in Michigan is disturbing. Data from the Venereal Disease Section, Michigan Department of Public Health, show that the rates for reports of syphilis and gonorrhea in the "other than White" population, at 18.4 per 1000, are eleven times greater than the rates in the White population, at 1.6 per 1000. These data suggest that if the AIDS virus becomes more prevalent among heterosexuals, then the likelihood of disproportionate spread within minority communities is high.

The potential for heterosexual spread of AIDS in the minority population is disturbing.

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SPECIAL PROBLEMS

Nutrition and Hunger

Poor nutritional practices are an important health risk factor. Illnesses that are influenced by diet include: diabetes, cancer, heart disease, and hypertension. Some researchers have estimated that proper diet could reduce the risk of non-insulin-dependent diabetes by 50 percent, cancer by 35 percent, and heart disease by 21 percent. These diseases are especially prevalent among minorities.

Access to food for the poor has emerged as an issue in Michigan as well as the rest of the nation. It has been said that the programs created in the United States in the 1960s and 1970s had "virtually eliminated" the problem of hunger, but reductions in federal funding for state food programs in the 1980s have regenerated the problem in a slightly different form. Today the isolated elderly, poor children at school and pregnant women are the most affected by these federal cut-backs. Many of these who lack access to adequate food resources are minorities. Also, culturally sensitive food choices need to be included in both publicly and privately subsidized feeding programs. Transportation to food program sites is especially difficult for elderly minority persons.

Minority residents need up-to-date nutritional information. Modification of dietary practices to achieve such goals as a reduction in obesity, although difficult to achieve, could have a significant impact on the health status of minority populations.

Environmental Hazards

A number of environmental hazards have a greater impact on members of minority communities than on the general population. The quality of housing has a significant effect on health status. Estimates indicate that as many as 17 percent of Michigan dwelling units today are substandard. Minorities, especially in our inner cities, occupy a disproportionate share of these substandard homes.

Health problems associated with housing include environmental hazards, communicable disease, and accidents. Among environmental hazards related to housing are infestations of rodents; various kinds of toxic substances such as asbestos and lead; improperly vented heating equipment which results in the accumulation of carbon monoxide; indoor air pollutants such as formaldehyde, nitrogen dioxide gases, and radon; and problems related to the water supply.

Blacks in the United States have been found to have higher concentrations of blood lead than Whites. Ethnic differences are more pronounced for young children than adults, and they often are associated with socioeconomic factors. The assimilation of lead into the human body occurs through the mouth, nasal passages, the skin and from the mother to fetus across the placenta. A common example is ingestion of lead paint chips. After lead has been assimilated into the body, it is altered by certain dietary compounds; for adults, about 50-60 percent is excreted before it is stored in the skeleton.

It is estimated that some 45,000 persons work in Michigan each year as migrant agricultural laborers; some 80 percent of these workers are Mexican Americans. Agriculture has the third highest rate of occupational injuries, ranking behind mining-

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

quarrying and construction. Those working in agriculture are also at increased risk for such diseases as leukemia, multiple myeloma, lymphoma and cancer of the prostrate and stomach. Agricultural laborers are more prone to parasitic infection than growers, and their diets provide lower nutritional intake.

Little is known about pesticide poisoning among migrant farmworkers in the state of Michigan. Since there is no monitoring system to report pesticide cases in the state, there is neither data on the prevalence of poisonings nor on the long-term effect of pesticide use on farmworkers.

One of the chief concerns of advocates for greater pesticide control is the exemption of agricultural workers from "Right to Know" legislation on chemical substances. Another concern is the need for a system to collect data on occurrences of pesticide poisonings.

Environmental issues such as the hazards from toxic dump sites, nuclear waste, and the protection of forests, rivers, and lakes receive considerable attention. The problems of the urban environment, which disproportionately affect minorities, also need increased attention. Many of the urban environmental hazards affect children and therefore have a long-term impact on our society.

Problems of Children

Because of the vulnerability of children, how well a society treats its children is an indication of the society's compassion as well as its future well being. As children develop physically, socially, and emotionally, they are dependent upon others to provide for their special health needs. For proper growth, they require a healthful environment, sufficient and nutritious food, freedom from injury, and an opportunity to learn good health habits.

Once a child passes through infancy, there is a period of pre-adolescent years which are the most healthful of the person's life. There are notable exceptions, however. Minority children with developmental disabilities have difficulty reaching their full potential without special intervention. Also, the "new morbidity" facing the children of today includes family disorganization, drug abuse, and injury.

Injury has a disproportionate impact on the young. In 1985 in Michigan, there were 29,256 hospitalizations due to injury of children (under age 20), making it the second leading cause of hospitalizations for children. Intentional injury was the leading cause of injury-related hospitalizations for Black children (895 cases). Death rates from drowning were slightly higher for Black children than White children. Deaths from burns were six times higher for Blacks than for Whites.

Children adopt many unhealthful behaviors that could influence their health as adults. For example, cigarette smoking is a major risk factor for cancer and cardiovascular disease. A 1986 national survey revealed that 19 percent of high school seniors smoke daily and that 68 percent had smoked at least once. Most smokers begin smoking during junior or senior high school.

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

Problems of the Elderly

Health is a central concern to the elderly since they are more susceptible to disease and ill health than are younger persons. A national survey indicated that 55 percent of all Blacks 65 or older regard their health to be only fair or poor, in contrast to 33 percent of White respondents. Poor health was also more likely to restrict the activities of older Blacks than older Whites (43.4 versus 30.8 restricted days per year).

The problems of the elderly are often the problems of minority women over the age of 65, who have already outlived their male counterparts.

A 1982 needs assessment survey of Detroit elderly (60 and over) showed that poor health, restricted mobility and insufficient income were among the most frequently mentioned problems. When asked what services they would like to see improved for seniors, 14 percent of the respondents mentioned home meal programs and another 14 percent mentioned home nursing care. When asked about local service programs, 20.5 percent of the elderly report that they were unaware of these programs.

According to the Michigan Office of Services to the Aging, almost all (96 percent) of the respondents reported that they were covered by health insurance. Those in poverty and minorities were most likely to perceive that they could not receive good medical care. Furthermore, minorities and the poor were more likely than other elderly to report using clinics and related forms of care.

The social support of family, friends and church members is extremely important to elderly Blacks, particularly to those with lower incomes. These supports have been shown to be important for daily activities as well as for participation in publicly subsidized services.

The elderly are requesting expansion of home delivered meals and home nursing services.

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

Access to Care

Minorities in Michigan often do not have adequate access to health care. Minority individuals suffer from poorer health status according to measures of premature mortality and excess morbidity. They are less likely to have seen a physician in the last year and use proportionately far fewer physician visits than do non-minorities. Three kinds of barriers to health care are central to minority access problems: physical access, economic factors, and cultural acceptability of services.

Physical barriers are a problem in rural areas because of the great distances to be traveled for routine primary care and hospital care. In urban areas, the public transportation depended upon by minorities is often expensive or unavailable at the time of day when services are needed.

Economic factors create barriers to health care in at least three ways. The most obvious is that persons unable to afford health care often do not seek it until forced to do so by the severity of the illness. Second, providers of health care are often unwilling to provide services to persons with no obvious means of paying for the care. Third, treating illness at an advanced stage is almost always much more expensive than preventive care or early intervention. Insurance factors compound these economic problems. The Michigan League for Human Service in its 1986 study of the uninsured in Michigan found uninsured rates of 11.4 percent for Blacks, 13.6 percent for Hispanics, and 18.3 percent for other minorities compared with a rate of 10.5 percent for non-Hispanic Whites. With the continuing problem of plant closings in Michigan, concern about loss of health insurance coverage by many workers is growing.

Cultural acceptability of services is an issue that also must be considered in attempts to enhance minority access to the health care system. The health care delivery system has evolved with partial and inadequate participation by minority communities. Refugees and immigrants from Southeast Asia have special access problems. Language difficulties are a barrier to care and there appear to be delays in seeking access to care. The number of immigrants from Southeast Asia arriving in Michigan between 1975 and 1985 has been estimated at 10,500. The heavy influx of immigrants in Arab American communities in Michigan has led to similar access problems for this population.

Jobs and Education

Minority groups have experienced historic discrimination that has placed a disproportionately large segment of their members in depressed economic situations. Although the specific forms of discrimination experienced by each minority group varied, systematic segregation in jobs continued into the twentieth century and was a common reality endured by all minority groups just a generation ago.

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

Some economic indicators show not only a slowing of progress but of regress in the status of minorities in recent years. Since 1975, the overall share of Black employment declined despite the relative increase in the Black population. Minority groups have been more severely affected than have Whites by the erosion of jobs in the manufacturing sector. Unemployment rates have continued to rise for minority group members in the 1980s despite an overall improvement in the unemployment rate for the state as a whole.

The deteriorating economic situation facing minority communities has had an especially devastating impact on minority youth. The Black youth unemployment rate in Michigan has not dropped below 50 percent since 1980 and has ranged as high as 68.3 percent in 1983. Black youth unemployment rates in the 1980s have been between 2.3 and 3.7 times as high as White youth unemployment rates.

The systemic problems of high unemployment levels for minorities and inequality in the educational arena are interrelated. Jobs at decent wages are a vital factor in family formation and maintenance. A supportive family environment and hope for the future are both important factors in educational success.

Minority high school drop-out rates are tragic; dropping-out often leads to unemployment or low wage, dead-end jobs. The latest figures available indicate that early drop-out rates for Hispanics and Blacks are more than double the rate for White children.

Number and Percentage of Michigan High School Students Dropping Out of School by Race/Ethnic Group, 1986

Race/Ethnic Group	Number	Percentage
American Indian	246	5.9%
Asian American	87	2.3%
Black	9,069	12.0%
Hispanic	810	10.9%
White	17,592	4.5%
TOTAL	27,804	5.8%

The deteriorating economic situation facing minority communities has had an especially devastating impact on minority youth.

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

Smoking Prevention and Cessation

Smoking is a factor in many poor health outcomes. Among the most important are lung cancer, esophageal cancer, ischemic heart disease, stroke, low birth weight, and complications of diabetes.

Not only is smoking prevalence higher within minority than non-minority communities, the tobacco industry has targeted advertising toward both Blacks and Hispanics. These advertisements appear in magazines for minorities and on billboards in minority neighborhoods. Furthermore, cigarette companies sponsor entertainment and cultural events attended predominately by minorities, and fund educational institutions that serve Blacks. These efforts of the tobacco industry increase the urgency and need to combat smoking within minority communities.

Although most smokers who have quit do so on their own, several evaluation studies of smoking cessation programs in Michigan have demonstrated success with outpatients, members of community organizations, and pregnant women. Research has also shown, however, that smokers are not likely to volunteer for a cessation program, especially if it involves financial costs. Many in the smoking cessation field believe that such programs are most effective when they occur within established organizations such as work places, clubs, churches and hospitals.

Mass media campaigns are a useful approach to smoking reduction. They have a considerable potential impact since they reach many individuals who are not otherwise exposed to smoking cessation messages such as the unemployed, homemakers, and others who may have limited contact with organizations.

Hypertension Prevention and Control

Hypertension, or high blood pressure, is one of the most deadly of the treatable diseases. Uncontrolled hypertension can lead to stroke, heart attacks, kidney disease and kidney failure, and accelerates diabetes complications.

There is some evidence that the incidence of hypertension can be decreased through stress reduction and related changes in lifestyle. For example, muscle relaxation and stress perception techniques and exercise programs have been devised to help individuals cope with stress and have been shown to decrease blood pressure. Dietary changes to reduce sodium intake and maintain ideal body weight are especially important for minorities. Blacks have been shown to both consume more salt and to be more sensitive to the hypertension inducing properties of salt than the White population.

Blood pressure screening, medication and good follow-up are important ingredients to successful programs. Some community groups, such as churches, employers and labor unions offer screening and counseling services.

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

Diabetes Education

Diabetes is the seventh leading cause of death in Michigan: people who have diabetes are twice as likely to be hospitalized as the non-diabetic population; persons with diabetes have twice as many heart attacks and twice as many strokes as those who do not have the disease; 50 percent of all non-traumatic amputations in the United States are performed on diabetics; 25 percent of all cases of kidney failure are caused by diabetes; diabetes is the leading cause of new blindness in the United States; and diabetes increases the incidence of life-threatening problems for newborns.

There is no known cure for diabetes. However, with close management of diabetes through prompt, adequate treatment and good self-management practices, certain of these major complications may be reduced and perhaps avoided altogether. Numerous studies show that diabetes patient education is an effective therapeutic intervention.

Patient education programs are most often conducted in the outpatient hospital setting and involve a routine series of visits which include checking for complications and educating the patient on subjects from diet and foot care to self-monitoring of blood sugar levels.

Reduction of Violence and Injury

Research on prevention of homicide is just beginning. Among the factors which have been cited as contributing to intentional injuries are: the prevalence of firearms; alcohol and drug abuse; poverty and joblessness; and the portrayal of violence in the media, particularly television. Affecting any of these factors would involve significant changes in the policy arena similar to those which have taken place in the automobile safety arena in the past three decades.

In recent years, a number of public health leaders have advanced the concept that homicide is a public health problem. In the past, homicide was viewed essentially as a problem for the criminal justice system.

Actions to restore a "sense of community" are needed. One such approach is the Ohio Department of Health's recent initiation of a Parenting for Peaceful Families Program." The program involves a community-based discussion series offering parents practical information about parenting skills and child development. The Ohio project is based on the concept that violence is a learned response and that peacemaking can be a learned response as well.

Teaching children and youth how to "get away clean" from potentially violent confrontations and restricting their access to handguns would also be beneficial.

Reduction of Low Birth Weight and Infant Mortality

Michigan has taken a number of steps in the last several years to address the state's high infant mortality rate. In 1985 legislation was enacted establishing prenatal care as a basic health service. Under this legislation, the Michigan Department of Public Health through the intermediary of local health departments provides reimbursement for the cost of prenatal care for those not covered by Medicaid if their incomes were at or below 185 percent of the poverty level and they were uninsured at the time of enrollment. This statewide program, known as Prenatal Postpartum Care

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(PPC), includes outreach, prenatal care, laboratory tests, vitamin and mineral supplements and education. Payment for labor and delivery services were added as of this year.

There are other effective measures that will help to reduce Michigan's unacceptably high minority infant death rates. They include: supplemental nutrition for pregnant women; reduction of alcohol use and cigarette consumption; voluntary access to family planning services; and parent education.

Reduction of Environmental Hazards

Interventions to reduce the impact of environmental hazards on minority health status involve changes in the policy arena. Housing appears to be an area of great concern, both in terms of its impact on the health of the population and because there is generally an absence of state public health policy in this area. Other environmental issues of importance are pesticides, sanitation, and occupational hazards.

The state health plan establishes the goal that all Michigan residents should have housing which meets minimum standards for structural adequacy, is not overcrowded, does not present hazards related to lead base paint poisoning, and is not infested with rodents. A plan objective is the reduction of unhealthful housing in Michigan.

Housing "livability standards" should be developed and provision made for the administration and enforcement of these standards.

Nutrition Improvement and Access to Food

Since nutrition is basic to health, it is important that minorities receive current information on nutrition so as not to lag behind the majority culture. The American Heart Association, the U.S. Department of Health and Human Services, the U.S. Department of Agriculture, the American Cancer Society, the National Cholesterol Education Project, and the American Dietetic Association are using radio and television to educate the public in general and minorities in particular.

In conjunction with nutrition education, publicly subsidized feeding programs should provide meals that are healthful and consistent with current dietary guidelines. Many foods that are plentiful in these programs such as cheese and butter are high in sodium, fat and calories. The Michigan Food Policy Report of the Michigan Department of Agriculture recommends content specification levels and more variety for the food items provided in emergency food programs. This could assist in making food choices available which could be tailored to minority group preferences.

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

RECOMMENDATIONS TO CLOSE THE GAP

A series of steps to be taken over the next two years are presented below. Some of these can be accomplished immediately by the Michigan Department of Public Health. Others will require cooperative effort from multiple units of state government, often in concert with our health partners in the business, labor, professional and voluntary communities. These measures, if fully implemented and continued over the long-term, will help make it possible for the generation of minorities born in the twenty-first century to enjoy health and longevity equal to that of the White population.

It is essential that progress be monitored by the proposed Office of Minority Health and by the Director of Public Health, with regular reports given to the Governor, Legislature and Public.

Determinations on funding levels have yet to be made. It is believed that many existing funding streams can be refocused to address specific minority needs. New interventions must be culture- and language-sensitive and funded through community organizations. Creative public and private funding partnerships must be identified and implemented. Finally, individual action to promote one's own health and to avail oneself of accessible health care will also help to lift the burden of ill health from Michigan's minority populations.

IMMEDIATE ACTIONS

I An Office of Minority Health Should be Established in the Department of Public Health.

The office should report to the Director of the Department and give persistent and continuing attention to minority health.

The office should be established by executive action and subsequently be placed into law in the Public Health Code (Act 368, P.A. 1978). Among the most important functions of the office are:

* Investigate and report to the Director of Public Health, Governor and Legislature on conditions affecting the health and welfare of minorities.
* Advise the Director of Public Health and the Governor's Human Services Cabinet Council on remedies for eliminating the gap between minority and majority health status.
* Advocate for adoption and implementation of effective measures to improve minority health.
* Provide consultation and technical assistance to agencies and groups attempting to improve minority health programs.
* Fund community-based organizations to conduct special research, demonstration and evaluation projects designed to develop model programs.

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- Increase public and intergovernmental awareness of minority health concerns.

- Form and coordinate a network of community health action teams to implement programs and monitor results.

II Data Collection on Minority Health Status Should Be Improved by the State and Local Public Health System, Hospitals, and Other Health Agencies.

The Department of Public Health and the Office of Health and Medical Affairs should improve collection of minority-specific birth, morbidity and mortality data on Blacks, Hispanics, Native Americans, Asian and Pacific Islanders, and Arab Americans. Among the most important steps are:

- Include items to more accurately identify members of each minority group on revised birth and death certificates.

- Distribute information on the best methods to collect accurate information and provide training to public and private data collection personnel.

- Conduct special surveys and epidemiological studies of minority health status and integrate them with on-going health research activities.

SHORT-TERM ACTIONS - 1988 TO 1990

III The Department of Public Health and the Governor's Human Services Cabinet Council Should Encourage Private Businesses, Labor Unions, Religious Organizations, Community Groups, and Civic Groups to Include "Closing the Minority Health Gap" Among their Highest Priorities.

Given the evidence of the vital importance of employment in improving the health status and general well-being of minority communities, the Governor, the Human Services Cabinet Council, the Governor's Cabinet Council on Human Investment, the Cabinet Council on Jobs and Economic Development and the Legislature should improve employment opportunities for minorities. Measures to be taken over the short-term include:

- Inform business, labor union and the public about the value of job development in improving minority health status.

- Create public-private enterprise partnerships targeting the job needs of central cities.

- Assure that the policies and practices of health providers and insurance companies are equitable and culturally and linguistically sensitive.

- Promote affirmative action employment goals throughout the health care industry.

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

IV. Significant Programs to Improve Minority Health Status Should be Funded. Health Promotion, Disease Prevention, and Risk Reduction Should Be Areas of Special Emphasis.

A. To reduce violence, the Departments of Public Health, Mental Health, and Social Services, working with the Human Services Cabinet Council, should launch a coordinated intergovernmental violence-prevention campaign.

* Promote parenting skills programs to aid families in their childrearing efforts and encourage them to use non-violent discipline.

* Develop and expand programs such as those in the Michigan Model for Comprehensive School Health Education to assist youth to learn non-violent conflict resolution skills and how to deal with stress, depression, anger, and suicidal feelings.

* Expand pre-school education classes to reach minority three and four year olds throughout Michigan.

* Encourage school programs that build children's self-esteem, independence, and hopefulness about their future.

* Expand the summer jobs for youth program to reach all unemployed youth in the state.

B. Programs dealing with environmental hazards should be expanded. The following actions should be taken:

* Establish housing livability standards.

* Assure the right of communities and workers to know about important environmental hazards, such as exposure to agricultural pesticides.

* Expand rodent control programs and control exposure to illegal toxic chemicals such as "roach milk."

* Reduce hazards of the indoor environment such as lead poisoning, asbestos and radon.

C. New health promotion and chronic disease prevention and control efforts are slated to be funded under the Michigan Health Initiative (Public Act 258 of 1987). These new activities should reach and benefit minority group members. Risk reduction program expansion is especially needed for drug, alcohol, and tobacco prevention and in hypertension and diabetes. The problem of AIDS is taking a disproportionate toll on minorities and special efforts will be needed. Adding new basic services in hypertension and diabetes will especially benefit minority populations.

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Source: https://www.industrydocuments.ucsf.edu/docs/rnjl0000

* Worksite wellness programs should target medium and small employers (under 500 employees) with high percentages of minorities in their work force.

* AIDS prevention and control programs should reach and benefit minority populations.

* Substance abuse prevention and control programs should give priority to minority populations.

* Publicly funded food programs should provide culturally sensitive alternative foods to minority recipients. Economic and logistic barriers to obtaining food should be removed.

* Hypertension screening, referral and followup services and diabetes outpatient education should be designated as basic health services.

* Assistance with payment for medications to clients with hypertension, diabetes, and other chronic conditions requiring medication should be provided.

* Services to chronically ill children should be improved by establishing a functional birth defects registry and increasing family assessment and case management services.

V. **Awareness of Minority Health Concerns Should be Expanded and Educational Opportunities for Minorities in the Health Professions Should Be Increased.**

A. A massive campaign to educate health providers and the general public about the gap in minority health status is needed. This campaign must be culturally and linguistically sensitive. Actions needed include:

* Develop and disseminate orientation materials for health service employees on the historical experiences and health needs of each racial minority group.

* Create a multi-media educational campaign on minority health status, giving special attention to counteracting the efforts of alcohol and tobacco companies who are targeting the minority community to increase sales.

B. Strong efforts are required to bring large numbers of minorities into the health care professions. Actions needed over the short-term include:

* Develop community coalitions to reduce high school drop out rates.

* Work with the State Board of Education to develop a plan

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graduate level training for health professions such as medicine, nursing, social work, nutrition and health education.

* Reinstitute the Master's of Public Health scholarship program for minority students at the University of Michigan School of Public Health.

* Work with the Department of Civil Service to expand the pool of minority applicants for health careers in state government.

* Continue to implement state Affirmative Action Programs to ensure that minority individuals are included as staff members at all levels of state government in proportion to their representation in the state population.

VI. The Human Services Cabinet Council Should Work to Identify and Implement Additional Recommendations from Recent Task Forces and Advisory Bodies Which Impact on Minority Health.

A. Many state task forces in recent years have addressed minority health issues. They include such diverse areas as Infant Mortality, Indian Health, Hispanic Needs Assessment, Black Children in Crisis, Adolescent Health, and others. Many of the recommendations in these reports have been implemented. However, the Human Services Cabinet Council should again review these documents and consider adopting additional recommendations. The Office of Minority Health should provide staff assistance for these activities.

B. In addition, the new Governor's Task Force on Access to Care should:

* Assure that the health service delivery system is sensitive to the cultural and linguistic needs of minority groups.

* Incorporate a specific focus on minority access to care.

All of Michigan has a major stake in improving the health of the minority population. Our ability to be economically competitive in a highly technological society depends on good health and high educational levels in both the White and minority communities.

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Copies of this Executive Summary Report or of the full report of the Task Force on Minority Health Affairs may be obtained by contacting:

Michigan Department of Public Health
Office of Minority Health
3423 N. Logan, P.O. Box 30195
Lansing, MI 48909

Phone (517) 335-9287

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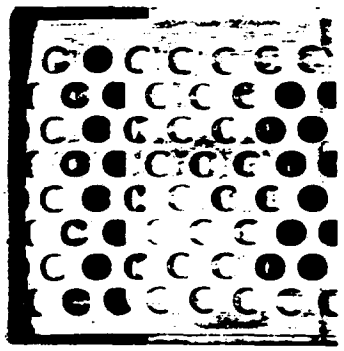

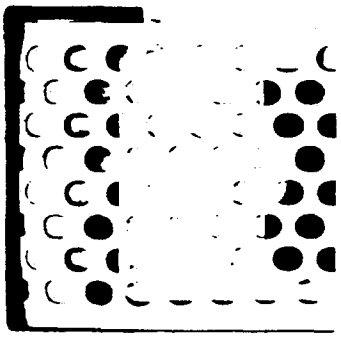

AUTHORITY: ACT 368 P.A. 1978, AS AMENDED

HP-94

"The Michigan Department of Public Health will not discriminate against any individual or group on the basis of race, color, religion, national origin or ancestry, age, sex, (or marital status) or handicap."

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